

Pediatrics & Parents

The newsletter for people who care for children

Richard J. Sagall, MD, Editor

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Critical Time for Obesity

The number of children with obesity increases with age. In a chart review study of 1,713 inner-city children one to five years old, 12% of the one year olds were overweight or obese. By age five, 51% of the kids were overweight or obese. The researchers found significant increases in weight between ages one to two and two to three years old. The prevalence of overweight or obesity didn't change from ages three to five.

According to Melissa Glassman, MD, the lead researcher, "The critical age period encompasses a major transition period for children, when they develop and establish food preferences and eating behaviors." She stresses, "It's important for parents to know that children model their eating preferences and behaviors on what their parents eat, that it can take multiple attempts of offering new foods before children like them, and that even very young children will stop eating on their own when they are full."

Pediatric News, 6/07

TV Watching and Adolescent Learning Problems

The more television adolescents watch, the more likely they are to have attention problems and academic failure. This is the conclusion of Jeffrey G. Johnson, PhD, of Columbia University, the director of a study of 678 children followed over a 21-year span.

Adolescence, according to Dr. Johnson, "is a critical period for cognitive development and educational advancement... Youths who watched three or more hours of television per day (termed 'frequent television viewing') were twice as likely as those who watched one hour of television per day to fail to obtain a postsecondary education by a mean age of 33 years." Frequent television watching was also significantly associated with attention problems, reduced competency in reading, failure to complete homework, disinterest in school, poor grades, negative attitude toward school, and academic failure.

Although the relationship may seem the other way around (children with attention problems tend to watch more television), Dr. Johnson believes this is "unlikely to explain the preponderance of the association."

What does Dr. Johnson recommend? "By encouraging youths to spend less than three hours per day watching television, parents, teachers, and health care professionals may be able to help reduce the likelihood that at-risk adolescents will develop persistent attention and learning difficulties."

Archives of Pediatrics & Adolescent Medicine, 5/07

Recent Child-Care Findings

By Jay Belsky, PhD

More than 20 years ago now, during the course of an invited address to The American Academy of Pediatrics, I called attention to “a slow, steady trickle of disconcerting evidence” linking lots of time spent in childcare, especially beginning very early in life, with, among other things, elevated levels of aggression and disobedience among children three to eight years of age. I further noted, when I was invited to publish my remarks in *Zero to Three*, the newsletter of the National Center for Infants, Toddlers and Families, in December 1986, that others “could, would and should” read the available research evidence differently, as it by no means conclusively and indisputably substantiated the developmental risks to which I called attention.

Nevertheless, I was roundly accused of “maligning” day care, being a misogynist, making employed mothers feel guilty and wanting to return to the days when women were kept barefoot and pregnant in the kitchen. This history is important to appreciate when it comes to understanding recent findings – and reactions to them – reported in the popular press linking somewhat increased levels of aggression and disobedience throughout the primary school years up to the age of 12 with more months and years spent in childcare centers before the start of school.

Perhaps what made my remarks so unwelcome back in the mid 1980s was that they represented a rather substantial change of mind on my part. Earlier, in 1978, I had co-authored a very well-received analysis of research on the effects of childcare that concluded that there existed little work actually substantiating widely embraced claims that childcare posed risks to children. What almost everyone refused to acknowledge at the time was how we qualified our seemingly “green-light-for-day-care” conclusions by calling attention to all that we still did not know, especially pertaining to the timing, quality, dosage and type of care that children experienced. Did it matter what kind of childcare children experienced? Did it matter how long they were in childcare?

The fact that research emerging between 1978 and 1986 led me to reconsider earlier conclusions seemed irrelevant when, as one observer accurately noted, “the daycare wars” broke out in response to my 1986 essay. Indeed, the only thing that seemed to matter was that I had broken the unwritten 11th commandment of the field of child development: “thou shall not speak ill of childcare” (in any manner, shape or form). Despite the

fact that I was calling attention to developmental risks associated with long hours of childcare initiated very early in life, it was easier to contend that I was against, for ideological reasons, any and all non-maternal childcare. But, as I have come to ask, “does the fact that the weatherman forecasts rain tomorrow mean that he is against sunshine?” Please keep this question in mind as you read further.

The eventual good news was that, in the face of the changing landscape for caring for America’s youngest citizens and heated scientific controversy about effects of daycare on infants and toddlers, the U.S. government, in the form of the National Institute of Child Health and Human Development (NICHD), launched in 1991 what became the largest, most comprehensive study of the potential impact of early childcare experience ever carried out. The NICHD Study of Early Child and Youth Development – and the numerous investigators collaborating on it, including me – has followed more than 1300 children beginning at birth through whatever childcare arrangements they experienced up to the start of school, then carefully studied their classroom experiences through 6th grade, all the time repeatedly assessing the functioning of children’s families and children’s social, emotional, cognitive and linguistic development. What the most recent findings, published in the March/April 2007 issue of the prestigious journal *Child Development*, show are the following:

1. The more months and years that children spent in childcare centers before starting school, the more aggressive and disobedient teachers rated them as being throughout their elementary school years, through 6th grade, around 12 years of age. Especially notable was that these seemingly adverse effects of high levels of center care experience held for children who experienced high, low or intermediate quality of childcare. And this all proved true after taking account of the type of family the child was from, how much or how little mothers experienced depression and even the quality of mother’s parenting and of family functioning more generally.
2. Although the quality of childcare did not seem to matter for children’s social adjustment, it did matter for their language development: The higher the quality of non-maternal care that children experienced before starting school – in whatever type of childcare they experienced (e.g., centers,

family daycare homes, nannies) – the larger their vocabularies throughout the elementary school years, through 5th grade, around age 11. Quality of childcare reflects how attentive, responsive, stimulating and caring caregivers were observed to be during assessments of childcare made when children were 6, 15, 24, 36 and 54 months of age.

3. The quality of mothering, which was assessed repeatedly for all children irrespective of whether or not they experienced lots or little childcare or high or low quality childcare, appeared far more influential with respect to children's social, emotional, cognitive and language development than did any aspect of childcare. In part this was because the parenting and other family measurements used in the study reflected shared genetic heritage as well as actual environmental influences of the family, and because the childcare effects described above were notably modest, if not small, in their magnitude.

So what does all this mean? The bottom line is that there is no single interpretation that all will agree on. But here is my take, which should not be presumed to be shared by all or even most of my collaborating investigators:

First, to those who want to herald the seemingly beneficial effects of high-quality care on language development but dismiss, disregard or explain away the seemingly adverse effects of dosage of center-based childcare on aggression/disobedience, I simply say, “feel free to do so as an advocate, politician or ideologue; but this posture cannot be sustained legitimately as a scientist or as someone who believes that research evidence matters. You simply cannot pick and choose the findings you like and dismiss or disregard those you don't – or shoot the messenger who shares the latter, as so many seem inclined to do.”

To those who want to say that none of these findings matter because the effects of childcare are too small to be meaningful, I have several responses. To begin with, I regard this as a logical, defensible point of view, one which I respect, even if I don't share. It is even handed and open minded. But it means concluding not just that amount of exposure to center care is of no real consequence for children's social functioning, but that whether or not a child has good, fair or poor quality of childcare does not matter either! It may, therefore, undermine policy-oriented arguments for both extending (paid) parental leave and for improving the quality of childcare.

I myself embrace a third point of view: Yes, these

childcare effects are limited, but the fact that they remain evident so long after the child has left childcare leads me to question the wisdom of dismissing them. This seems especially sound when the dismissals come from so many who have claimed for years, if not decades, that the results that the NICHD-Study detected simply would not emerge – because (a) the only thing that matters about childcare with respect to child development is quality; (b) that when quality is good everything is okay; and (c) that children's social, cognitive and linguistic development is enhanced by good quality childcare. Why, after all, grant credibility to those who have proven to be wrong in claiming that childcare experience does not contribute to aggression and disobedience when it is of high quality and that the benefits of high quality care are substantial and broad? From the standpoint of scientific evidence emerging from the NICHD-Study, these conclusions represent beliefs rather than empirically substantiated facts.

To my mind, parents should consider the NICHD-Study results summarized above as they make their childcare choices. I doubt that research evidence on the effects of childcare ever has been fully determinative for any parents, nor do I think they should. Many sources of information inform parents' decision making. What I think our study does is provide more such information, that is, scientific grist, for the childcare decision-making mill.

What actually concern me the most are the collective or cumulative effects of childcare – on classrooms, schools and communities. Think of it this way: Although we all know that the air pollution in Los Angeles is, in large measure, generated by cars, no single vehicle contributes all that much to the overall level of pollution in the city. What matters is the (large) number of cars spewing out low levels of pollutants.

Thus, in a day and age when more and more children, at younger and younger ages, spend more and more time in childcare centers (and other arrangements), often of limited quality, what is the consequence for larger social systems of the modest effects the NICHD-Study has detected? Does a 1st, 3rd or 6th grade teacher with lots of children with long histories of center-based care, especially if of limited quality, spend more time trying to manage her class and less time actually teaching it – or teaching at a lower level – than another teacher whose classroom is comprised of many fewer such children? And what goes on in playgrounds and in neighborhoods when there are many children with certain childcare histories that may, at the level of the individual child, only increase levels of aggression and disobedience by even just a little bit? Are there more fights? Is there more bullying? Is there less respect for

adults and teachers? And what happens when modest or small effects of childcare meet up with perhaps similar modest or small effects generated by exposure to divorce, or to repeated family moves, or to poverty or family stress?

The truth is that none of us knows the answers to these questions; I certainly know I don't. But I also know that those who have been wrong so often before about childcare effects, and who remain bent on dismissing any mention of disconcerting findings, often by "shooting the messenger," have not seriously considered the questions themselves. I encourage us all to do so.

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When It's Not Just a Urinary Tract Infection

By Bradley P. Kropp, MD and Jake Klein, MS, CPNP

Urinary tract infections (UTIs) in small children have a variety of causes, including poor toilet-training habits. Often, these conditions resolve with a course of antibiotics and a simple review of good bathroom habit practices, such as always wiping from front to back and voiding (urinating) completely. In some cases, particularly when urinary tract infections are recurrent and involve fevers (also known as febrile UTIs), they may be a symptom of a potentially serious urinary condition in children.

The condition, known as vesicoureteral reflux (VUR), affects approximately one percent of all children. It occurs when urine flows the wrong way through the ureters, or the tubes that connect the kidneys to the bladder. Ordinarily, urine flows in one direction only: from the kidneys through the ureters to the bladder. In children with VUR, however, a malformation of the ureters allows urine to flow backwards from the bladder through one or both ureters and up towards the kidneys.

There are two causes of VUR: the more common, known as primary VUR, is present at birth and occurs during fetal development. This form is an anatomical malformation of the area where the ureter enters the bladder. Less common is secondary VUR, which is caused by an obstruction in the bladder or urethra and generally the result of high-pressure bladder situations such as neurogenic bladders, posterior urethral valves (found in males), or simply because of bad toileting habits such as "holding" urine. Both types of VUR cause retrograde, or backwards, flow of urine towards the kidneys.

VUR tends to run in families: if a parent has VUR, up to half of his or her children will also have it. If a child has VUR, as many as one-third of his or her siblings will also have it.

When VUR is present alone, it has no symptoms. However, the diagnosis of reflux is often confirmed during the complete work-up of a urinary tract infection. The symptoms of a urinary tract infection can include, but are not limited to, fever, dysuria (burning with urination), back or flank pain, urinary urgency or frequency, cloudy or foul-smelling urine, nausea, and vomiting.

If left untreated, serious consequences of VUR include kidney infections (pyelonephritis) that can occur when infected urine flows back into the kidneys. These infections can damage the kidneys with renal scarring which can eventually lead to poor kidney function and high blood pressure. For this reason, VUR should be diagnosed and treated as early as possible. VUR is usually diagnosed after a child has a urinary tract infection and sometimes from abnormal prenatal ultrasound findings. The average age at diagnosis is three to four years but it may be diagnosed at any age, even in newborn babies or older children. A health care professional will ask about the history of your child's symptoms, do a physical examination and may elect to perform several tests if VUR is suspected.

One such test is called a voiding cystourethrogram (VCUG) or NCG (nuclear cystogram), often referred to as "voiding studies." These are X-rays of the bladder where a thin plastic tube called a catheter is inserted into the urethra. Fluid containing an X-ray dye or

radioactive tracer is then injected through the tube until the bladder is full, and then the child is asked to urinate. Pictures of the bladder reveal whether the dye goes backwards up to one or both kidneys. These tests usually take 15 to 20 minutes.

The VCUG is usually done as a first-line study because it determines the severity of the condition and provides optimal imaging of the anatomy. The severity is determined using an accurate grading system of grade I (mild) to grade V (severe). Nuclear cystograms (NCG), on the other hand, are best utilized as follow-up studies because they expose the patient to less radiation. Although NCG does not allow for precise grading (i.e. mild-moderate-severe) or good imaging of the anatomy, it will show if reflux is present or not.

When treating VUR, the primary goal is the rapid and effective prevention of febrile UTIs to ultimately reduce the risk of long-term consequences. Milder grades of VUR may resolve spontaneously. However, the more severe the VUR, the less likely it will go away on its own. Half of the children affected require treatment. There are three treatment options for VUR:

- Antibiotics may be used to prevent UTIs until the VUR resolves on its own. This preventative treatment may take several years, and parents must comply with the strict dosing schedule. Antibiotics are considered “first line therapy” for all but the most severe grades of reflux. No long-term complications from daily antibiotic usage have been reported. However, bacterial resistance has been recognized as a consequence of antibiotic treatment.
- There are two types of surgeries performed to correct VUR.
 1. Open surgery can repair the valve in the ureter to prevent reflux from occurring. This treatment is highly effective, but usually requires a short hospitalization, accompanied with pain and recovery time, which is typical of any open surgical procedure.
 2. Endoscopic treatment involves injecting a gel-type substance where the ureter joins the bladder, creating a cushion that effectively prevents the urine from flowing back. Currently, DEFLUX is the only approved endoscopic VUR treatment in the United States. DEFLUX is indicated for VUR grades II through IV. This procedure is performed on an outpatient basis and is usually associated with minimal pain and recovery time.

In summary, UTIs DO NOT cause reflux, and reflux DOES NOT cause UTIs. However, all parents and their children can benefit from identification of UTI risk factors and an understanding of optimal bowel and bladder habits as a lifestyle commitment. Your physician can help you to identify and correct any potentially harmful elimination habits such as holding or straining. In addition, parents should be aware of the importance of maintaining good genital hygiene, encouraging proper “voiding” posture, and of promoting optimal fluid intake.

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Jake Klein is the clinic manager as well as a full-time Certified Pediatric Nurse Practitioner at the Pediatric Urology Clinic in Children’s Hospital located on the Health Sciences Center campus in Oklahoma City. He specializes in voiding dysfunction and all other pediatric urology problems. He is an active member of the Pediatric Urology Nurses Specialists, and many other organizations.

ATV Injuries

All-terrain-vehicles (ATVs) and other non-auto motorized vehicles are taking their toll on our kids. From 1990 to 2003, more than 1.2 million children one month to 19 years old were injured severely enough to require emergency room treatment. Seventy-seven percent of the injured children were boys, and the average age of the injured children was 12.7 years old.

Forty-four percent of the injured children were riding ATVs, 21% two-wheeled off-road vehicles, and 14% go-carts/buggies. The most common injury was a contusion or abrasion (28%), followed by fracture (24%) and laceration (20%). A disconcerting finding is that the number of injuries is increasing. There was an 86% increase from 1990 (70,500 injuries) to 2003 (130,900).

Medical News Today, 2/23/07



Children in Hospitals

By John E. Monaco, MD

Asthma and Obesity... the Struggle Continues

I don't remember exactly when the pager went off the first time. It was late, that much I know... probably two or three in the morning. The ER doc informed me that he was struggling to stabilize an asthmatic 14-year-old boy. Charles, the boy in question, was brought from his home in an ambulance in severe distress. According to his mom he had awakened suddenly unable to breathe. She could hear him struggling from the next room. She offered him a breathing treatment with the family's home nebulizer. It helped slightly, but as soon as the treatment was completed, his "tightness" worsened again, only now he was beginning to panic. Charles' mother began another treatment and simultaneously called 911.

The ambulance arrived quickly to find this 14 year old in severe respiratory distress. They started an IV and placed him on oxygen. As they rolled him into the ambulance, they called the ER to inform the staff that they were on their way with a very sick asthmatic. The EMS team also informed the ER of another complicating factor. This middle school student, with impending respiratory failure, weighed 280 lbs.

This fact, Charles' extreme overweight, was also kept from me until the end of the ER doc's report. At first it didn't register. After all, it was the middle of the night, and I had been awakened from a sound sleep! Eventually, however, I realized that his weight would be the most difficult factor to combat in order to relieve his asthma symptoms.

Charles remained in the hospital for five days, two to three days longer than the usual hospital stay for asthma. During his hospitalization he exhibited many of the characteristics of extremely overweight children and their respiratory challenges. First and foremost, of course, was his asthma.

The relationship between asthma and obesity is complex, but there is no question that the rise in childhood obesity is paralleled almost exactly by the rise in the incidence and severity of asthma. Just getting to know Charles and observing him in the hospital gave us a

glimpse into the everyday challenges he faces because of his weight. Seeing his struggle with the fundamental functions of life gives one a sense of the vicious cycle of obesity.

It must be said, first of all, how impressive Charles' pure size was. He literally filled the hospital bed. This fact becomes important when one realizes how difficult it is, then, to simply move when one has this much body to work with. Every movement left Charles severely out of breath. And because just having to move tired him out, he did so as little as he could get away with. This, of course, made recovery difficult, and long-term rehabilitation challenging.

When he fell asleep, we were impressed with the degree of upper airway obstruction he had. He snored and had "pauses" in his respiratory cycle just like those of a middle-aged man with sleep apnea. In fact, we found CPAP (continuous positive airway pressure) to be the most effective modality to deliver breathing treatment to Charles as well as assure oxygenation while he was asleep. This is the same modality used on older men with sleep apnea.

Not to our surprise, we also found Charles to have high blood sugar. Some of this was due to the medicines we gave him to combat his asthma (steroids, bronchodilators, etc). But it would not be unusual for a child such as Charles to be exhibiting the beginnings of type II ("adult" onset) diabetes because of his obesity. His mother told us that diabetes did run in the family. And, as one might expect, his blood pressure also ran much higher than that of an average-weight child of the same age. This will come back to haunt him later in life.

Charles' asthma symptoms did eventually improve. The frustration for us came when it was time for him to be discharged; not that trying to alleviate his wheezing wasn't frustrating enough! Charles was still obese. There was nothing we could do about that during the few days that he was in the hospital. We knew he would go home to the same habits, family life and psychological profile that got him in this state to begin with. Of course we talked to him and his family about the

problem, which is more than a lot of people are doing these days. In fact, in my experience I have found that pediatricians often avoid the topic of obesity because it is so uncomfortable to the patients and their families, not to mention frustrating for them as well!

Charles was able to leave the hospital in a better state than he had come in; he was able to breathe on his own. But the sad thing is that one day we may not be able to save Charles. He is the type of asthmatic – mainly because of his extreme weight – that could experience irreversible bronchospasm and sudden death. It's difficult to tell this to a family, who, no matter how much their child weighs, thinks only optimistically about their child's long life. It has become somewhat

of a cliché that this generation of children may be the first in American history not to outlive their parents, due to the obesity problem. Such news may seem like an abstract concept, utilized for political debates and public health lectures, until one comes face to face with a patient like Charles. Children like Charles may not be so lucky to make it to the ER the next time they wake up in the middle of the night struggling to breathe.

John E. Monaco, MD, is board certified in both Pediatrics and Pediatric Critical Care. His new book, Moondance to Eternity, is now available. You can hear him talk about his book in podcast 37. He lives and works in Tampa, Florida. He welcomes your comments, suggestions, and thoughts on his observations.

Vehicle Safety For Children: A Quick Guide

By Roy Benaroch, MD

Car Safety Seats

- Try out the seat you like before you buy it for the way it fits your vehicle and your child.
- Avoid used car seats; destroy any car seat that has been in a serious accident.
- Always use the car seat, even when your car is idle. Don't turn the engine on until kids are strapped in, and do not unstrap kids until the engine is off.
- For help with installation, review the instruction manual for the car seat and your vehicle. You can also find information about a car seat installation check at www.seatcheck.org, or through many fire stations.
- All infants should ride facing backwards until one year of age AND 20 pounds. If your baby has reached 20 pounds but is not yet one year of age, use a backwards-facing convertible seat. You can also start using a backwards-facing convertible seat when your baby is too tall for the infant seat – consult the manufacturer's specifications.
- Infant-only seats are designed to face backwards ONLY; convertible car seats are for bigger babies and can face backwards or forwards.
- Your child should stay in the convertible seat until about 40 pounds. Move your child from the convertible seat to a booster when she reaches the top weight or height limit on the seat.
- NEVER install the car seat in the front passenger seat. The safest place for a child of any age is in the back seat; the middle of the back seat is best.

Safe Driving

- Keep your vehicle well maintained, especially the tires, brakes, lights, and windshield wipers.
- Don't drive while distracted.
- Avoid talking on a cell phone, eating, or fiddling with a music player while driving.
- Mirrors so you can "peek" at your children are a bad idea. Keep your eyes on the road.
- Many prescription and non-prescription medicines medications can dull a driver's reactions. Combinations of medicines, or medicines with alcohol, can be especially deadly.
- Do not drive your children if you have had any alcohol to drink. Even one drink will slow a driver's reflexes.
- Stay defensive and aware of everything in the road. Assume every other driver is NOT going to be as careful as you. Take care of yourself.
- Watch for road hazards, especially in construction areas.
- Be a good role model – always wear your seat belt.
- Don't leave your young child alone in or around cars.
- For bigger vehicles, consider purchasing a rear-view camera to protect children who might not be visible. Or, get into the habit of backing into your garage or driveway, so you don't have to back out when children are around.



Perspectives on Parenting

By Michael K. Meyerhoff, EdD

Goodness of Fit

There is an interesting concept in the area of developmental psychology called “goodness of fit.” Basically, it involves the notion that a favorable match between a child’s temperament and the practices of his parents lead to healthy psychological adjustment in the long run.

It seems clear that children are not all born with the same temperament. Some kids are sensitive and irritable while others are oblivious and calm. Some are outgoing and some are introverted. Some are cautious and some are fearless. And it is clear that not all parents are the same in this regard either.

So let’s consider the intrepid toddler versus the timid toddler. I’m sure you all know a young child who, when you take him to the playground and before you can blink, has scampered to the top of the monkey bars and is swinging from his ankles. And I’m sure you all also know a young child who, when you take him to the playground, will stand at the fence for at least an hour and then will only slowly approach the equipment in small steps.

And let’s consider the daredevil mom and dad versus the anxiety-ridden mom and dad. You all know parents who – despite the domestication imposed on them by having a child – remain skydivers and bungee jumpers. And you all know parents who – despite surviving the countless everyday incidents that befall their child – still will rush him to the emergency room if he so much as burps.

Now match the intrepid toddler together with the anxiety-ridden mom and dad. The kid gets to the playground and scampers to the top of the monkey bars. His parents run after him screaming, “Stop! Stop! You’re going to get hurt! Stop! Stop!” And put the timid toddler together with the daredevil mom and dad. The kid gets to the playground and clings to the fence. His parents pull him away and drag him to the monkey bars cajoling, “C’mon! C’mon! What are you afraid of? C’mon! C’mon!” While these scenarios may seem exaggerated, you get the point: it is obvious that neither one is likely to be conducive to children’s sound psychological health.

What is nice about “goodness of fit” however is that it does not require a match between a child’s temperament and the temperament of his parents. It merely requires a match between his temperament and his parents’ practices. We cannot change who we are, but we can control what we do.

Therefore, achieving “goodness of fit” first necessitates respecting the diversity among human beings. People are different, and it is critical to recognize that “different” does not necessarily imply “better” or “worse,” and “equal” does not necessarily mean “the same.” If you and your child have different temperaments, it is imperative to accept that this may not be particularly convenient, but it is okay.

The second part is considerably more difficult. Achieving “goodness of fit” necessitates controlling yourself. Depending on the degree of discrepancy between your and your kid’s temperaments, you may find it nearly impossible to do this on occasion, but for the sake of your child, you must strive.

Of course, I’m not suggesting that you abandon your parental responsibilities or aspirations. In the above examples, the anxiety-ridden mom and dad certainly can keep a close eye on their intrepid toddler and urge him to be careful. And the daredevil mom and dad definitely need not refrain from encouraging their timid toddler to loosen up and take a chance. But unreasonable restriction or excessive force can be and should be avoided. Otherwise, it is likely to be mom and dad who eventually will be avoided by the child.

I recall growing up with parents who had distinctly different temperaments than mine. My father was very quiet and studious. I was an energetic athlete. It seemed to me that my father simply could not – and did not – care to understand me. He constantly sought to restrict my participation in sports and never ceased trying to push me into more “appropriate” hobbies such as coin and stamp collecting. The conflict between us grew steadily and finally exploded during my adolescent years. Although we eventually reconciled, we both suffered through an unhealthy estrangement that lasted for over a decade.

Meanwhile, my mother was a careful planner and organizer. I was inclined to do things on the spur of the moment and thrived under pressure. I always had a penchant for leaving my school assignments to the last minute. This made my mother crazy. At first, she chastised me and attempted to show me how to manage my time more prudently. But when she saw that I was performing quite well on my own and only chafing under her direction, she ceased and desisted. I'm sure I was responsible for her having many sleepless nights. On the other hand, even during my tumultuous teen and early adult years, we never lost our close emotional connection.

Of course, despite the lessons afforded me when I was young, I struggled mightily with these issues when it was my turn to be on the other side. Although athletic, I am not particularly adventurous. I am terrified of roller coasters and other such machines at so-called "amusement" parks. Regrettably, I have grandchildren who can't get enough of them. I have not enjoyed going on these rides with eyes closed, hands clenched, and stomach in knots, but I have delighted in the grateful hugs I received afterwards.

And although spontaneous, I am also consumed by compulsive neatness. Anything messy makes me nuts. Regrettably, I have grandchildren who live to play in the mud, smear finger paints over everything in sight, and find all sorts of applications for shaving cream. Again, it is all I can do to participate in their activities without launching into a fit of apoplexy, but the incredible smiles on their little faces somehow do make it all enjoyable as well as endurable.

So take stock of yourself and your kid. There are bound to be at least some significant temperamental differences. Don't be ashamed of who you are or disappointed in who he is. And don't neglect to contradict and take control when dealing with issues of safety, propriety, or progress. But do be prepared to behave in a manner that may be contrary to your basic nature if it means permitting your child to behave in a manner that suits him. Achieving "goodness of fit" ultimately is in both of your best interests.

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My Child and ADHD: Chances of Being Diagnosed

By Helen Schneider, PhD

Where We Stand: Facts and Controversies

Attention-Deficit/Hyperactivity Disorder (ADHD) is the most commonly diagnosed behavioral disorder, affecting 4% to 12% of school-age children in the United States. In recent years, statistics show an increase in the number of cases of ADHD and a rise in drug prescriptions to treat the disorder. In addition, individual communities and population subgroups vary widely in the ADHD prevalence and drug consumption. For example, per capita consumption of psychostimulant drugs in New Hampshire is more than three times that of the neighboring New York. Within states, per capita consumption for some counties is 10 times that of other communities.

Recent Early Childhood Longitudinal Study (ECLS) data of the elementary school children in the United States reveals that more than twice as many children in the Midwest region are diagnosed with ADHD (28.1% of all children) than in the West region (13.3% of all children). Since moving to the Midwest does not cause

inattention or hyperactivity, the question arises: why are children in certain areas and population subgroups more likely to be diagnosed with ADHD and more likely to be treated with medication to control their behavior than children in other regions and populations? Much of the controversy surrounding the growth in ADHD rates in the U.S. stems from the perception that the diagnosis results more from children's environments rather than from their actual conditions per se.

Child Characteristics vs. Environment

ADHD is widely perceived as an affluent white boys' disease. Research has shown that African-American, Hispanic and Asian children and girls of any race with ADHD are less likely than white boys to get proper medical attention for their problem. Besides child characteristics, family and school environment proved to be very important. Thus, two otherwise identical children with identical externalizing behavior patterns if placed in different environments can have different outcomes of ADHD identification and treatment.

Although the effect of the household income and area affluence on ADHD diagnosis is not absolutely clear, there is a positive relationship between community affluence and per-capita use of psychostimulant drugs. Thus, children from more affluent backgrounds are more likely to receive treatment. Other environmental characteristics that prove to be related to the ADHD diagnosis across studies include family structure. Absence of biological father or mother (as well as death in the family) proved to have a significant impact on instances of ADHD.

ADHD is unique since it is often first suggested by school teachers and parents rather than physicians. In fact, in only 14.4% of cases, a primary care physician or a mental health professional suggests the diagnosis. Thus, family and school perceptions and characteristics, as well as personal attitudes of parents and teachers, often affect ADHD identification. For example, children of U.S.-born parents are more likely to be diagnosed, independent of income, area, and child characteristics. At least in part, this data can be explained by family attitudes as well as differences in information that parents have about ADHD.

Teachers Critical but Dependent on State Policies

School teachers play an important role in ADHD diagnosis since the symptoms of ADHD are often exhibited almost entirely in classroom settings. Teachers observe many children on an everyday basis and may be better suited to point out a behavioral problem than parents. However, a child's behavior may stand out more in a more homogeneous classroom where a small deviation from a norm may seem problematic.

On the other hand, in classrooms with children from many different backgrounds, many different behaviors may be accepted and a similar child may fit within the accepted behavioral norm. Thus, diversity may explain some of the variance in ADHD that we observe across geographic areas and child's peers and classroom composition may play an important role.

Besides observations of child behavior, school teachers are also pressured to comply with state accountability laws similar to the No Child Left Behind Act. Such laws come in many varieties, from report cards and ratings to rewards and sanctions of schools and teachers based on students' performance. Children living in states with stricter accountability laws are more likely to have higher ADHD diagnoses rates. Thus, faced with accountability pressures, teachers are more likely to suggest medical solutions to problems of disruptive behavior and poor academic performance.

From a policy perspective, it is difficult to say whether or not the relationship between accountability laws and ADHD rates is a cause for concern. On one hand, teachers who are more motivated to improve students' academic performance may be more likely to identify and help potential ADHD cases. On the other hand, the pressures that accompany accountability laws may encourage teachers and school officials to treat students with psychostimulant drugs, rather than address other possible aspects of the situation (e.g. large class sizes, unengaging teaching methods, etc.).

It Matters Where You Live

All of the above concerns forced many states to pass ADHD laws that prohibit school employees from providing psychiatric diagnoses, administering any psychiatric examinations, and suggesting prescription drugs. To date, Connecticut, Virginia, Colorado, Illinois, and Michigan passed such laws. Many other states are considering similar regulation. These laws intend to make sure that diagnosis and prescription drugs come from doctors who are qualified to make such determinations. In addition, most states prohibit schools from punishing students or parents for refusing prescription drugs. Thus, any parent has the right to refuse to administer psychostimulant drugs (such as Ritalin) to their child and such refusal does not constitute neglect. Moreover, schools cannot expel a child for parental refusal to treat a student with ADHD prescription drugs. Some states (e.g. Colorado and Texas) encourage schools to try substitutes for medication and behavioral therapy and not administer prescription drugs for what they perceive are problems of discipline.

Because there are no objective blood or lab tests for ADHD and other such learning problems, the diagnoses have always been controversial. Some state laws explicitly doubt the validity of ADHD and effectiveness of medical treatments to treat the disorder. Subjectivity of the ADHD diagnosis drives the high variance in observed diagnoses and treatment rates between and within states. Although in some areas children may be over-diagnosed, it is more disconcerting that female and non-white students do not receive adequate diagnosis and treatment. Stigma of being labeled as ADHD may also contribute to under-identification in some environments.

Steps in the Right Direction

We recommend that more information be made available to parents of untreated children. For now, here's what interested parents need to keep in mind:

- Seek more information about ADHD tendencies and growth rates to make an informed choice.
- Know your rights. Learn about your state's and

school's regulations. In most states, school personnel cannot pressure parents to administer prescription drugs to treat ADHD, nor can they expel a child for failure to receive medical treatment.

- Do not dismiss a teacher's observations of child's behavior since his/her goal is to improve academic performance. However, a physician can provide an informed and a more "unbiased" diagnosis.
- Spare no effort to receive the right diagnosis and treatment. Even if you refuse to treat your child with drugs, other accommodations (e.g. extra test

time and stress-free environment during tests) may improve your child's well-being and academic performance.

Helen Schneider holds a PhD in Policy Analysis and Management from Cornell University and is currently a faculty member in the Economics Department of the University of Texas, Austin. Her research interests include the effect of school policies on child health, ADHD diagnosis and treatment, hospital supply of charity care, hospital mergers and hospital quality.

Humidified Air for Croup?

For generations, doctors have recommended using moist air – either warm or cold – to parents for treating their children with laryngotracheobronchitis (croup). A recent review of the literature found nothing that supports this treatment.

Surprisingly, whether or not humidifying air helps children with croup hasn't been studied well. Animal studies show that dry warm or cool air does a better job of opening the airways than moist warm or cool air.

There are no standard national guidelines in this country for the treatment of croup. However, evidenced-based guidelines from Canada and Australia don't recommend moist or humidified air. Oral steroids are the best treatment for mild to moderate croup. More severe cases should be treated in an emergency room.

The Cochrane Database of Systematic Reviews, 2006 Issue 4

Drugs for Diarrhea

There's nothing messier – or smellier – than a young child with diarrhea. The best initial treatment of a child with diarrhea is with fluids and gradually reintroducing a normal diet. Replacing the lost fluid is more important than stopping the outflow. Sometimes, parents feel compelled to buy an over-the-counter anti-diarrheal to try to stop their child's loose stools and may buy a product that contains the drug loperamide (sold as Imodium, Kaopectate Caplet, Maalox Anti-Diarrheal and others).

Recent research shows that using loperamide in children, particularly children three years old and younger, has little to no benefit and may cause serious side ef-

fects. The results indicated that the children that received loperamide did not have significantly fewer loose stools than the children that received the placebo. And, eight of the 927 children receiving the loperamide experienced serious side effects, including ileus (paralysis of the intestines), lethargy, and death, whereas none of the children receiving the placebo had any serious outcomes. The study also found that the younger the child that was given loperamide, the greater the risk of experiencing a serious side effect.

"Certainly for kids under three years there seems no reason to risk using something like loperamide that, albeit rare, has been associated with morbidity and mortality," said Robert Baker, MD, a pediatric gastroenterologist at the Children's Hospital of Buffalo, NY. He continued, "I do not recommend loperamide even for the older child. It is true that adverse outcomes are less likely in the older child but not unheard of. As with the younger child, these episodes (of diarrhea) are short and not life-threatening."

Dehydration is the real danger of diarrhea. If a child with diarrhea shows signs of dehydration – decreased urine output, no tears, dry mouth, and doughy skin – then seek immediate medical help. Viruses cause most diarrhea, However, bloody diarrhea is usually due to bacteria and is another reason to seek medical assistance.

Pediatric News, 5/07

PediaTrick

A Bitter Pill

A way to disguise the metallic taste of some medications, especially certain antibiotics, is to eat a few salt potato chips before and after taking the pill. The very salty taste masks the bitterness.

Clinician Reviews, 8/05

Making Our Homes Safe For Children

By John C. LeBlanc, MD, MSC

We parents want to ensure our children grow up to become healthy functioning adults. We therefore provide a safe, nurturing and loving environment and are always on the watch for threats such as disease, abduction, violence and injuries. But what are the most common threats, and what can we do about them?

Most of us have never met a family that has lost a child through an infectious disease or a stranger abduction; these are rare events. Yet most of us know of a family or friend whose child has been injured or killed because of a motor vehicle collision, a fall, a poisoning or a burn. In fact, injuries cause almost half of all deaths among children aged one to four years, and most home injuries are caused by falls from heights, burns and scalds, and poisonings.

These injuries are not events we hear about in the media because they are commonplace and appear to be random accidents. But, injuries are not accidents. Professionals involved in injury prevention do not like to use the word 'accident' because it suggests that the event was beyond one's control and therefore not preventable. In fact, for any injury, one can analyze what events led up to the injury and therefore consider what could be done in the future to prevent this injury.

In order to better understand why home injuries occur, several pediatricians and emergency physicians conducted a study from 1995-1996 to see if the households of injured children differed in some systematic ways from the households of non-injured children. The study used records from five Canadian pediatric hospital emergency departments that represented most children's emergency departments in North America or Europe. The unique feature of this study was the use of home visitors to personally assess the homes of 702 consenting families for the presence of hazards. This method was costly but more reliable than simply asking people to report if certain hazards were present or not in their households. One drawback was that we were not able to visit the home before the injury occurred, so we were forced to assume that the state of the household was similar to the time that the injury actually occurred, about one month before we visited.

The visitors assessed the home for the presence of 19 hazards that are related to falls, burns, scalds, ingestions or choking. For falls we assessed: "baby walker,"

"no device to prevent child opening basement door," "no gates at stairs," "no safety straps on diaper change table," "bedroom windows open easily and beyond six inches," "living room windows open easily and beyond six inches." For poisonings or ingestions we assessed: "choking hazards within child's reach in the bedroom and living room," "no child-resistant lids in bathroom medicine cabinets," "no household cleaning supplies have child-resistant lids," "easy access to bathroom beauty supplies, medications," and "easy access to household cleaning supplies." For burns or scalds we assessed: "kitchen tap water temperature greater than 54°C (130°F)," "dangling cords from kettle or kitchen appliances," "no stove guard to prevent child from grabbing pots," "no or a non-functioning smoke alarm," "no fire extinguisher," and "matches or lighters within child's reach."

We found the following: 21% of homes with children under one year had a baby walker, 17% of all homes had no functioning smoke alarm, and 51% had no fire extinguisher. We were also able to estimate how likely it was that houses of children who visited the emergency department for a home injury had particular hazards compared to houses of children who visited for other reasons, such as asthma, fever or diarrhea. We found, among households with children less than one year old, that 10 of 31 households with injured children contained a baby walker compared to only three of 31 households with children who did not have an injury, more than a threefold difference. We also found that households of injured children more often had choking hazards within a child's reach, no child-resistant lids in bathroom medicine cabinets, and either a non-functioning or no smoke alarm.

What's the bottom line? Homes of injured children differed in some aspects, but all homes, whether of injured or non-injured children, had an average of six hazards. It is difficult to make a home completely hazard free since children are on the move all of the time and caregivers have to balance many tasks. So what can we do?

Solutions to minimize home injuries can be divided into passive and active tasks. Passive tasks are those that need to be done only once or a few times, such as turning down the temperature on one's water heater to the recommended 49°C (120°F). Water heaters are often

factory set much higher to provide more hot water (and, to the manufacturer's benefit, to shorten the life of the heater) but this can lead to serious burns if somehow a child gains access to a freshly drawn hot bath.

Other passive and highly recommended measures include installing window guards that prevent windows from being opened beyond six inches and removing baby walkers from the house. The latter is a noteworthy hazard since these lead to thousands of injuries and deaths each year but provide no benefit to babies. Baby walkers have been banned in several countries, including Canada, but are still freely available in the United States.

Active measures are those that require the caregiver to do something each time the hazard is present. For example, one must continuously look out for items that can cause choking in a toddler, and one must close a stair gate each time one uses the stairs. Compared to passive measures, which pay off whether or not one pays attention to them, active tasks require ongoing

efforts in order to be effective. Unfortunately, lack of taking active measures causes most injuries in the home. Nothing replaces the continual supervision of conscientious caregivers. Below is a list of practical measures one can do in one's home.

Dr. John LeBlanc is a pediatrician and Associate Professor of Pediatrics and Psychiatry at Dalhousie University, Halifax Nova Scotia, Canada. In addition to working and teaching at the IWK Health Centre, Dr. LeBlanc has published research on a variety of public health issues such as home safety, the use of bicycle helmets, mental health issues including screening for emotional and behavioural disorders in a school setting and evaluation of school-based violence prevention programs. In addition to his research and clinical work, Dr. LeBlanc chairs the Psychosocial Paediatrics Committee of the Canadian Paediatric Society and serves on the directing council for the Centre of Excellence for Early Child Development and the executive team of the National Centre of Excellence "Promoting Relationships and Eliminating Violence" (PREVNET).

Practical Tips to Prevent Household Injuries

Falls

- Remove the wheels on your baby walker! There is no such thing as a 'non-tippable' walker.
- Use stair gates at the top and bottom of each set of stairs.
- Make sure the stair gate you use for the top of the stairs is certified for that.
- Buy doorknob covers that prevent toddlers from opening doors to stairs.
- Install window stops that prevent windows from opening more than six inches.
- Guard against your baby falling while you're changing diapers. Use a change table with straps and always have one hand on your baby. The first time she rolls over may be when you turn away to get something.

Burns and Scalds

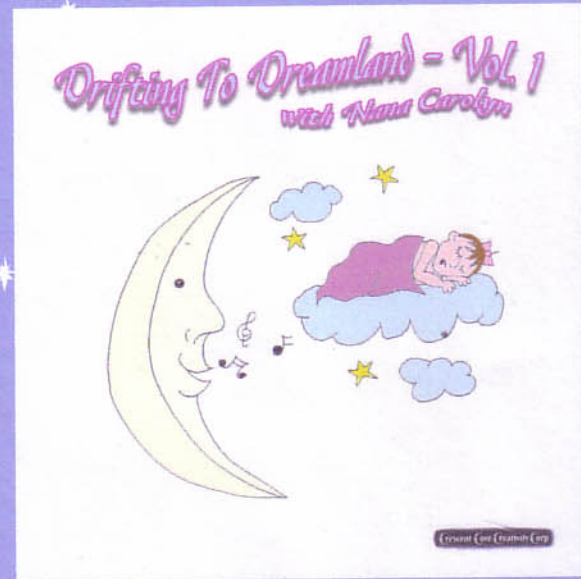
- Buy covers for unused electrical outlets.
- Make sure appliance cords don't dangle or are not within reach of toddlers.
- Cook using back burners and with pot handles turned inwards.
- Buy a plastic stove guard to prevent toddlers from touching burners or pots on the stove.
- Always drink hot liquids from cups with lids whenever young children are around. Save your mugs and teacups for adults-only events.

- Reduce the temperature of your water heater to 49°C or 120°F. This is hot enough for the dishwasher and more than hot enough for bathing. You can ask your landlord, call an electrician or do it yourself. The control is usually behind a small panel on your water heater and is easy to set.
- Make sure you have at least one smoke alarm on each level of your home.
- Check batteries on your smoke alarms at least twice a year (e.g., when you adjust clocks for daylight savings time).
- Place a fire extinguisher that is easily reached from your kitchen.

Poisoning and Choking

- Make sure all medicines are stored in child-resistant containers.
- Make sure household cleaning supplies are stored safely away (not under the kitchen sink!)
- Watch out for small objects; if they can fit through an empty toilet paper roll, they can block your child's airway.
- If you don't have 911 service, make sure the number of your nearest poison control center is near your phone.

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or for a Holiday or birthday gift



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Your Questions Answered

Alvin Eden, MD, Roy Benaroch, MD, and Sharon Fried Buchalter, PhD, answer your questions. Dr. Eden practices in Forest Hills, NY. Dr. Benaroch's practice is in Atlanta, GA. Dr. Buchalter is a clinical psychologist author.

Send your questions to QandA@pedsforparents.com or Pediatrics for Parents, PO Box 219, Gloucester, MA 01931. Please keep them general in nature as we can't give specific advice nor suggest treatment for your child. All such questions should be asked of your child's doctor.

Eating Disorder

Q I am a mother of a 10-year-old girl who is obsessed with weight loss. She is very thin for her age. She refuses to eat breakfast or dinner because she is afraid she will gain too much weight. I often find her in her bedroom looking in the mirror to see if her clothes are getting any smaller. I also find food hidden in her bedroom that I had given her to eat for dinner. Can you give me suggestions on how to end this obsession? Signed, "A Concerned Mom"

A Your concern for your daughter is clear and I'm glad you wrote. An eating disorder is an obsession with food and weight that harms a person's well being. Although we all worry about our weight sometimes, people with eating disorders go to extremes. People with anorexia are obsessed with being thin and do not want to eat. People with bulimia eat a lot of food at once and then throw up or use laxatives to remove the food from the body. Possible causes of eating disorders include feeling stressed out or upset about something in your life, or feeling the need to be "in control." If there are many stressors in someone's life, often what she eats is the only control she feels she has. Society and the media also put a lot of pressure on people to be thin, especially young, school-age girls.

Sit down with your daughter. Find out what's going on in her life. See if there is anything that's been bothering her. She may not open up to you right away, but just listen. Also, stay aware of the way your daughter looks. Is she so thin that she looks sick? Does her weight fluctuate a lot? Do you notice any of the warning signs of eating disorders, such as:

- Unnatural concern about body weight
- Obsession with calories, fat grams and food
- Use of medicines to keep from gaining weight
- Throwing up after meals
- Refusing to eat or lying about how much was eaten
- Fainting
- Over-exercising
- Not having periods

Realizing that your daughter may have a problem is a big step, and you should be commended for caring so much. Since eating disorders are a very complex and serious matter, it would be impossible to cover it fully in this column. What I'd like you to do is to seek professional help. Start with your family doctor, who can then recommend further help such as an eating disorder specialist or a psychologist. Good luck to you and your family.

Sharon Fried Buchalter

Reading to Babies

Q My friend reads to her 9-month-old girl. Isn't that too early and a waste of time?

A No, it is not. I congratulate your friend and consider her a real positive parent for doing so.

The evidence is very clear that the best thing parents can do to help their children succeed in school to achieve their maximum intellectual potential is to encourage reading, and the earlier the better.

There is a wonderful national organization called "Reach Out and Read" that supplies books to parents, clergies and hospitals to be given to parents. These are age-appropriate books and they start for six-month-old infants.

I cannot emphasize strongly enough how important it is to instill the love for books in your young children. As I say many times each day in my office to the parents of my little patients, "less T.V. and more reading."

Alvin Eden

Constipation

Q I have a one-year-old granddaughter that is on whole milk and she gets constipated about every third day to the point where we have to give her a baby enema in order for her to go, and then it's really hard and too hard for her to push out and she

tears and bleeds. Other than offer her different foods, which we are trying, is there anything else we can do to help her?

A Constipation in a baby or toddler can become a very difficult problem. Babies will quickly learn that it hurts to have a bowel movement, and will deliberately try to hold it in. So what happens? The next stool becomes even bigger, harder, and more painful to pass. You should try to stop this cycle as soon as possible.

Some dietary changes may help. Increasing fruit, vegetable, and water intake will make stools softer. Offering juice can help, too. Prune, pear, and mango juices work best. But don't start mixing juice into every cup of water, or you may not be able to get the child to ever drink plain water again.

It is true that some children find dairy products constipating, especially when milk and cheese are consumed with every meal. But for most children, dairy is an ideal source of calcium, vitamin A, and vitamin D. You can try to cut back the dairy, but you'll need to find other good calcium sources.

Usually, dietary changes alone won't completely eliminate constipation, and a safe stool softener will be needed. Good over-the-counter choices include milk of magnesia or Miralax. Bulk laxatives like Metamucil can work, too, but they can actually make constipation worse if the child doesn't drink enough water. Mineral oil is very effective, but should not be used in babies less than a year of age. Since your granddaughter is so young, her family should consult with their pediatrician for the correct safe dosing of any stool softener.

You do want to stop using enemas as soon as possible. Babies can get used to that sort of stimulation, and may learn to become dependent on that for a bowel movement. It is better to rely on a safe oral stool softener than a suppository or enema for the treatment of constipation in children.

Roy Benaroch

Febrile Seizures

Q My 13-month-old girl had a temperature of 104°F and started to shake all over. The doctor told me that Amanda had a simple "febrile seizure" and there was nothing to worry about. She is now fine but I'm still worried.

A Your doctor was right. The seizure your daughter suffered was caused by the high fever itself, and this type of seizure is harmless. It does not result in

any brain damage. It certainly is frightening for parents to watch their child have a convulsion but it's important to remain calm. What you need to do is to turn the child onto her side and keep her head cradled to prevent it from banging into a hard surface. Then call your doctor and cool off your child.

These simple fever seizures usually last less than five minutes, and your daughter will be as good as new afterward. But, these children need to be examined in order to determine the cause of fever. Fever-reducing medication should be given under the direction of your child's doctor.

There is no specific treatment for a simple febrile seizure, except to lower the temperature and treat the infection. And there are no medications to prevent another febrile seizure in the future. My best advice is not to allow your child's temperature from rising to the level that triggered the first seizure by starting fever-reducing medication, such as Tylenol or Advil as soon as your child develops fever.

A final word: These febrile seizures are seen most often between six months and two years of age. As your child grows older, the chances of another seizure decrease. Very few fever seizures occur after three years of age.

Alvin Eden

Dental Visits

Q We're preparing to take our 8-year-old daughter to the dentist for another check-up. The minute I told her we were going, she started crying and saying she was scared. How can I ease her fears and make the trip more pleasant and less traumatic for her?

A It is certainly not unusual for children to feel anxious about visiting the dentist or the doctor; it can be easy for them to associate these people with pain. Going to the dentist is even scary for many adults!

The most important thing you can do is to acknowledge your daughter's fears. Instead of telling her there's nothing to be afraid of, help her confront her fears. Sit down with her and ask her to tell you what it is about going to the dentist that she doesn't like. If she isn't sure what she's scared of, help her come up with reasons why she might be scared. Once your daughter talks through her concerns, help identify her feelings by saying things like, "So you're worried about the drill," or "You don't like when they make you keep your mouth wide open like that. I understand. It's natural to feel that way." Sometimes just talking about our fears helps ease them.

Once you and your daughter have talked through her feelings, explain the importance of going to the dentist. You can say something like, "I know you don't like it when the dentist looks in your mouth. I know it might be a little uncomfortable. I don't like that much either. But, by getting check-ups and taking care of your teeth, it will help your mouth stay healthy and avoid problems in the future." Sometimes reassurance about why we have to do unpleasant things helps.

It may also help to use other techniques to help make your daughter's visit to the dentist as pleasant as possible. Ask her if there's anything either of you can do to

help her relax when she is there. For example, she can bring along a favorite toy or stuffed animal. She could squeeze your hand while the dentist is examining her. You can even practice deep breathing and relaxation techniques. Another helpful activity is to have your daughter visualize a pleasant place and imagine what it feels like to be there — the smells, the sights, the sounds, etc. (e.g., Disney World, the beach, a water park, the zoo, etc.) Another thing to do is to act out the dentist's visit ahead of time. This helps take the mystery out of the office visit and will give your daughter the knowledge she needs ahead of time to feel empowered when she gets there.

Sharon Fried Buchalter

Explaining Death to Your Child

By Cynthia MacGregor

"Mommy, what happened to Great-Grandpa?"

That's a tough question to answer when Great-Grandpa has died and when this is your child's first experience with death. It's difficult enough to tell a child that someone he loves has "gone away forever" - whatever words you put it in - but to have to explain the concept of death itself to a child for the first time is even more difficult.

This is an article whose information I hope you don't need to use for a long time... but inevitably, in every family, a death happens and needs an explanation. It may be the next-door neighbor, or a teacher, or it may indeed be Great-Grandpa. Your child may be four, or seven, or nine years old. But sooner or later, however old your child and whoever has died, you're going to have to deal with telling your child that someone she knew and perhaps loved isn't going to be around anymore. And if this is her first experience with death, you're going have to explain the whole concept of death to her. It's not an easy concept to explain.

An analogy I have used before - both in real life and in my book for little kids, *Why Do People Die?* - is that people's bodies can get worn out just like sneakers. When sneakers get old and well-worn, they are used up and won't work right anymore. And that happens to people's bodies too.

Eventually the parts of the body just stop working. The heart stops beating. The lungs stop breathing. The body is worn out. And the person stops being alive.

It's a difficult concept for a small child to wrap his or her mind around, especially if he has never had any experience with death (such as the death of a pet). There are some things you want to make sure he understands, though. The first thing is that Great-Grandpa did not die on purpose and leave him behind thoughtlessly. You want to make sure the child understands that death is not an option that Great-Grandpa chose. He didn't desert the child. He didn't choose to go away.

The second thing is not to confuse the child with comparisons to sleeping. Some parents will say, "He's asleep forever," or "He went to sleep, but he won't ever wake up." Such comparisons can easily frighten a child. She may well think, "What if I go to sleep tonight and I don't ever wake up again?" This very scary thought can lead to sleep disturbances or sleep resistance in a child... and with good reason. So do not liken death to sleep in explaining it to your child.

Which brings us to yet another concern in explaining death to kids: That is that explaining death to them might engender fear that this might happen to them. (I don't mean some day when they're very old, but now.) Let's get back to the sneaker analogy we were talking about a minute ago. The comparison of worn-out bodies and worn-out sneakers works better, of course, if the person who died was indeed Great-Grandpa (or some other person of a comparable age). Then, not only does the sneaker analogy work, but (along with your reassurance that Great-Grandpa, like the sneakers, was very old and his body badly worn out), it can be explained as something that happens to very old people.

But what if the person who died was Aunt Courtney, your 32-year-old sister?

If your child has ever had a shirt, pair of jeans, or other clothing that didn't last as long as it should but wore out prematurely, you can – if it's appropriate to the cause of death and to the child's age and level of understanding – remind him of that and say that's what happened to Aunt Courtney: Her body wore out unexpectedly early. Or, if this is the case, you can say that Aunt Courtney got very sick with a very bad serious illness – not something like a cold or a tummyache or anything your child has ever experienced. You want to stress this point, because otherwise your child might fear that the next little snuffle or other bug he gets is a precursor to death like what happened to Aunt Courtney.

Naturally, it's not only the prospect of his or her own death that can concern your child. It's also the possibility that you (or your child's other parent) will die and leave him motherless or fatherless. For a very young child, a simple promise of "I'm not going anywhere and neither is Daddy" should suffice. For a child old enough to reason that "Aunt Courtney didn't plan to die either," reassurance that "I'm in good health and take care of myself, and very very very very few people my age die!" may be sufficient to ease his concerns.

Of course, if Aunt Courtney died as the result of an automobile crash, some other form of possibly preventable accident, or some self-induced harm (such as drug addiction), you can point out that her death, though unfortunate, teaches a lesson: "This is why it's important to cross the street carefully." "This is why I always drive safely, and when you grow up, you need to drive safely too." "This is why I take care of my body by eating right, getting exercise, and getting enough sleep, and why I try to make sure that you do those things too." "This is why you need to always buckle your seat belt in the car."

What if your child asks, "What happens to someone after they die?" The answer is going to depend not only on your child's age but on your personal and religious beliefs. Do you believe in heaven? In reincarnation? Neither of the above? If you believe in heaven, you can certainly say, "The person goes to heaven to live with God and the angels." Reincarnation may be difficult to explain to a four year old, but an eight year old can grasp the concept. And even with a four year old, you can try explaining that some people believe that the spirit of a dead person goes into a new baby that's waiting to be born. Uncertain yourself? You can honestly answer, "No one knows for sure. Some people believe the person's soul goes to heaven. Other people

believe other things. Nobody can be certain. And Great-Grandpa can't come back to tell us."

Should you bring a child to a funeral or other memorial service? That depends on the child's age, on how sensitive he is, on what type of service it's going to be... and on whether it's to feature an open or closed coffin. I personally am strongly against letting small kids view the deceased person lying in the coffin. Even with a closed coffin, the sight and sound of many grownups crying may be more than a small child is ready to handle, as may other aspects of the service. You have to make the final call on this one; you best know your own child's emotional makeup, as well as his or her age.

Even if the child doesn't attend the funeral, you can tell him what a funeral is: a religious service at which a clergyperson, and maybe some other people too (maybe you're going to be one of them), gets up and says nice things about the person who died, and says some prayers too.

Another thing parents say to kids that may be disconcerting is, "Great-Grandpa is in heaven now, but he's certainly looking down and watching you." The idea of being watched at every moment – even when the child thinks she's alone and is doing something private – may not be the comforting thought you intended it to be. The child may believe that both God and Santa Claus watch over her actions, but both God and Santa have so many people to watch... while Great-Grandpa is focused on the family. Did he see me pick my nose? Is he watching when I rub myself between my legs? What about when I was in front of my mirror, trying to look like my stuck-up older sister? I didn't mean for anyone to see that!

Two more thoughts that you should emphasize to your child of any age:

The first is that it's all right to cry. Of course he misses Great-Grandpa or Aunt Courtney. This is not the time to "be brave" and hold back the tears. Let them flow. It's all right. No one is going to criticize him for crying. He loved Great-Grandpa, he's going to miss Great-Grandpa, and it's perfectly all right for him to cry about Great-Grandpa dying. (Even if the person who died was nice Ms. Miller next door, he's allowed to cry. Death is a big thing - and at least a little bit scary - and it's perfectly all right for him to cry. Remember, he's probably not crying only because Ms. Miller died. He's just gotten his first intimation of his own mortality... and yours.)

The other thought is that, though Great-Grandpa is gone, his memory lives on in your child's heart, and in

the heart of everyone who remembers Great-Grandpa and loved or even just liked him. Family, friends, people who used to know him at work, neighbors, fishing buddies or people he used to play cards or golf or go bowling with... everyone who remembers him feels sad now that he's gone, but everyone has stories they remember about Great-Grandpa.

Encourage your child to remember his stories too... and perhaps to put them down on paper as well. (If he's too young to write them himself, he can dictate them to you.) Empower your child to help keep memories of Great-Grandpa alive through remembering him, telling stories about him, and maybe even writing those stories down. This will leave him feeling there's something

positive he can do for himself... and for Great-Grandpa. And that will help him to cope with the loss.

Author of over 50 published books, Cynthia MacGregor writes on many subjects, but the majority of her books are aimed either at parents or at kids. Some of her books tackle "difficult" topics, such as two books written for kids that explain divorce and one that deals with stepfamilies, one for little kids that explains death, and another for little kids that explain's Mom's new pregnancy. But she also writes on happier subjects, as in the I Love You book, and with a sense of humor when it's called for, as in What Do You Know About Manners? A former New Yorker, Cynthia has lived in South Florida since 1984.

Parents Influence Kids' Behavior in Cyberspace More Than They Know: In One Ear and Out to Cyberspace

By Diane Smirolfo

With an overwhelming majority of children accessing the Internet, and concern for their safety paramount, encouraging good judgment as they navigate their way through cyberspace is important. Protecting them with censoring devices, such as Internet filters and parental spyware, has become commonplace. But, even technological solutions aren't always enough. According to recent research, the majority of kids know what's right and wrong in the real world, but their online behavior is less admirable.

"While the Internet mostly mirrors kids' real world behaviors, technology can amplify bad behavior and can make ethical lapses like cheating or illegal downloading easier," said Anastasia Goodstein, author of *Totally Wired: What Teens and Tweens are Really Doing Online* and founder of Ypulse.com. "This is why it's crucial for parents to engage in conversations with their children about the choices they make online and off."

Consider the disparity among children when asked about ethical scenarios in the "real world" and cyberspace. According to the results of a 2007 Harris Interactive-Business Software Alliance study of 1,196 youth (ages eight to 18), 94% said taking something from a store without paying for it is "always wrong" and 85% consider copying someone else's an-

swers on a test as "always wrong." Yet just 61% say it is "always wrong" to download software without paying for it, and 59% report the same for downloading music or movies from the Internet without paying for them.

"When one is copying [test answers], the victim is viewed as a person, but copying online is considered a victimless crime," explains Dr. Laurence Steinberg, psychology professor at Temple University and author of *The 10 Basic Principles of Good Parenting*. "It is easier to steal when the victim can be depersonalized."

According to the Harris study, number of youth ages 8 to 18 that reported their most used and important electronic device.

Computer at home	35%
Cell phone	20%
Video game system (i.e., Xbox, Playstation).....	17%
Television.....	14%
iPod or other MP3 player	8%

Parents probably will be surprised to hear that they are not the primary consideration in kids' minds when it comes to the bad consequences of online behavior. Parents' impact is growing, however, and results of recent studies vary based on children who are given rules about online behavior and those who are not.

When youth in the Harris study were asked what worries them about downloading

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Enter to win a \$50 Amazon gift certificate. Go to www.pedsforparents.com, click on "Contest" and then enter Contest 1. The password is "health."

software, music, movies, or games from the Internet without paying, the top responses given were fear of downloading a computer virus (62%), downloading spyware (51%) and getting in trouble with the law (52%). Interestingly, youth's fear of getting in trouble with parents ranked fourth (48%). When comparing the 2007 study with the 2006 study, however, parental influence grew. In 2006, 40% of kids reported getting in trouble with parents as a deterrent.

Parental involvement is a critical reinforcement in continuing to raise awareness and educating their children about acting responsibly – and ethically – online. In fact, youth reported in the 2007 study that parental oversight is a significant motivator and key influencing factor in their online behavior. When comparing the young people without parental rules to youth with parental rules, kids reported they are more likely to surf the Web (87% without parental rules vs. 63% with rules), buy something (55% vs. 19%), download software (52% vs. 19%), and download music without paying a download fee (47% vs. 16%).

Importance of their home computers and cell phones increases and importance of video game systems and televisions decreases with age.		
Most important device		
Youth ages	8-12	13-18
Home computers	27%	41%
Cell phone	8%	29%
Video game system (i.e., Xbox, Playstation)	27%	9%
Television	22%	8%

Fortunately, the survey found that parents had warned more than half of the students about dangerous, illegal online behaviors. Imposing rules and ensuring your children abide by them may seem to be an old-fashioned concept for cyberspace, but it works.

Encouraging kids to view cyberspace appropriately is key. Many resources exist, such as www.cybertreehouse.com where they can play games and learn about being good cybercitizens. Parents can visit www.playitcybersafe.com for free resources to teach

children about cyberethics, including a four-page comic book curriculum, fact sheets, articles and more.

Diane Smiroldo is Vice President of Public Affairs at Business Software Alliance. She directs the organization's communications and public affairs programs including marketing and education activities, media relations, global branding and message development programs.

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Help Your Child Build a Winning Way With Words

By Raymond J. Huntington, PhD

Solid reading skills are vital for success on many of the tests your child will take between Kindergarten and high school graduation – including the SAT and ACT. Students therefore need to possess a strong vocabulary and be confident in their ability to discern the meanings of many words. Yet the benefits of a broad vocabulary go far beyond test scores. Children and adults who have a way with words possess communications skills that are vital for success in both school and life. Here are some tips for building word power:

Read Extensively

The best way to develop a broad vocabulary is to read extensively from pre-school onward. Whether your child is enjoying the adventures of Ernest Hemingway or reading books about his or her favorite subject or hobby, viewing words in the context of a narrative builds an intuitive understanding of their meanings. Your son might simply shrug when seeing the words “gargantuan” and “gilded” on a vocabulary test, for

example, but he'll probably understand the meaning right away if he's reading a passage that notes “With more than 2,200 passengers, including a dozen millionaires, on board for what was supposed to be the fastest-ever Atlantic crossing, the gargantuan Titanic was the most technologically advanced maritime vessel of the Gilded Age.”

Learn How to “Decode” Words

While the best way to score stellar results on vocabulary tests is to have a thorough understanding of the words being tested, students can also make a well-educated guess about a word's meaning by recognizing certain clues. One of the most effective strategies is to understand the meanings of common prefixes and suffixes.

- A few examples include:
- Un – Generally means “not,” as in unacceptable, unusual and unaware
 - Re – Usually means “again,” as in return, remember and reiterate

In, and im – Usually refer to something being “in” or “not,” as in ineligible, immutable and implausible

Inter – Commonly means “between,” as in interloper, or intervention

Dis – Usually means “apart,” as in disassociate, dissension and disagree

Sym and syn – Refer to being “together,” as in symmetrical and synergy

Common suffixes – Letters at the end of words – will provide clues as well. When you see the letters “less” at the end of a word, the word will often mean something related to “without,” as in hopeless, thoughtless and careless. “Ful” refers to being “full,” as in hopeful, helpful and thoughtful.

An excellent resource for building word power is www.dictionary.com, a site that enables visitors to check the meanings and spellings of words. The site also has numerous games and puzzles that build word knowledge and vocabulary skills in a fun way. Simply subscribing – for free – to “word of the day” will introduce a new word every morning as your child logs on to email. Your child can also learn the most common prefixes, suffixes and word roots by typing these key words into the “search” box.

Make Flashcards of New Words

Once your child learns the most common prefixes, suf-

fixes and word roots, he or she can use www.dictionary.com or a regular dictionary along with reading assignments to learn words that

incorporate them. Try setting a goal – such as learning five new words a day for five days a week. Once your child finds a new word, he or she should make a flash card, with the word on one side and the definition on the other. Your son or daughter should then keep the flashcards on hand and run through them often to strengthen familiarity with the words. Setting a goal to learn five new words a day for five days a week can boost your child’s vocabulary by 200 words in just two months.

Special Tip for Parents

A great way to help your child learn challenging but important words and get past speed bumps to comprehension is to look at homework reading exercises before your child tackles them and help your child pre-learn the words that might create problems. Make a list of these words. Work alongside your child to “decode” their meanings by looking at prefixes and suffixes, and then using them in a sentence or conversation to show the context before he or she starts reading the passage. If you spot challenging words such as “verify” and “enigmatic” in a passage for example, you can help your child pre-learn the words by using them in a sentence, such as “I’m going to verify that you’ve completed your homework,” or discussing why Arthur Conan Doyle’s enigmatic Sherlock Holmes stories are so exciting.

Become Familiar with Vocabulary Categories.

Students must also understand the various categories of words. Synonyms, for example, refer to two or more words that have a similar meaning. Antonyms are words that have opposite meanings. Your child should also be familiar with analogies, which express a connection between words, as in “bark is to dog as meow is to cat,” and “clothes are to fabric as tires are to rubber.”

Dr. Raymond J. Huntington and Eileen Huntington are co-founders of Huntington Learning Center, which has helped children achieve success in school for 29 years. For more information about how Huntington can help your child, call 1 800 CAN LEARN.

Sticks and Stones Can Break Your Bones but Words Can Break Your Heart: Preventing Disability Harassment in School

By Randy Chapman

Jeremy was in tears and Brenda had reached the boiling point. Jeremy was in 7th grade and used a wheelchair. Everything at school had been fine until the new kid transferred in. The new kid had started calling Jeremy the “crip.” Jeremy could handle some kidding about his using a wheelchair, but there was a mean and ridiculing tone to the way the new kid called him “crip.” At first, Brenda, being the patient and wise mother she is, had counseled Jeremy to just ignore the new

kid; with time, the teasing would stop. After all, sticks and stones could break your bones, but words could never hurt you. But, a few of the other kids thought the new kid was cool and began calling Jeremy “crip” as well. It had gotten so bad that he no longer looked forward to going to school. Brenda had complained to the school principal, but his response had been that boys will be boys and Jeremy probably needed to get used to the “real world.” Brenda knew that people got

teased in the real world, but she expected some adult control of this behavior.

One day, the new kid placed some chairs in front of the wheel chair accessible rest room door and Jeremy wasn't able to maneuver his wheel chair into the rest room. Fortunately, one of his friends saw the predicament and moved the chairs before Jeremy wet himself.

Because of the Individuals with Disabilities Education Act, children with disabilities successfully go to school with children without disabilities. But sometimes, incidents like this one, in which students with disabilities are picked on because they have a disability, do occur. There are two federal laws, Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA) that prohibit discrimination against students with disabilities. These laws require school districts to make sure that the school environment is free from abusive and intimidating behavior towards students with disabilities by other students or school staff. This kind of behavior is considered disability harassment. Here is some information to help you recognize and handle disability harassment in school.

What is Disability Harassment?

Disability harassment is intimidating or abusive behavior toward a student based on a disability. This behavior can create a hostile environment in the school and deny a student equal access to the school program. Harassing a student based on his disability violates Section 504 of the Rehabilitation Act and the Americans with Disabilities Act. Under these laws schools have an affirmative obligation to make sure that students are not harassed because they have a disability.

What Are Some Examples of Disability Harassment?

Calling students with disabilities names, drawing pictures or writing statements, or other conduct that is physically threatening, harmful, or humiliating are all forms of harassment. For example:

- Students who continually refer to a student with dyslexia as dumb
- Students who repeatedly place classroom furniture in the way of a wheelchair-bound student
- A school administrator who denies a student with a disability access to lunch, field trips, assemblies and extracurricular activities as punishment for a student who takes time off from school to attend therapy sessions or a medical appointment
- Students who continually taunt or belittle a student with mental retardation by mocking or intimidating the student

- A teacher who belittles or criticizes a student with a disability because the student uses accommodations in class.

What Should Parents Do if They Feel Their Children with Disabilities are Being Harassed?

The parent should first contact the school principal to discuss the harassment. If the harassment continues, the parent should contact the Section 504/ADA Coordinator for the school district. Section 504 and the ADA require that school districts designate an individual to coordinate the school district's compliance with these two federal laws prohibiting discrimination based on disability. The 504/ADA coordinator should be able to help the parents resolve the harassment. Parents may also contact the Office for Civil Rights (OCR) within the United States Department of Education. The Office for Civil Rights is the federal agency that is responsible for enforcing Section 504 and the ADA in the public school system. Parents can obtain more information regarding the Office for Civil Rights and disability harassment, including how to file a complaint, through its website at www.ed.gov/ocr.

How Can Schools and School Staff Prevent Disability Harassment?

School districts should have a clear policy prohibiting disability discrimination. The policy should specifically describe disability harassment and clearly state that it is unacceptable. School staff should be trained in how to recognize and handle potential disability harassment. Moreover, parents, students, teachers, and other school staff should be encouraged to discuss disability harassment and report it if it occurs.

The school district should have a clear grievance process to be used by students, parents, educators and others if they think an individual is being harassed due to his disability. The school district should widely publicize the procedures for handling disability harassment so that students, parents, school employees, and the community are aware of what it is, that it will not be tolerated, and where and how complaints involving disability harassment are handled.

Finally, if the school district receives a complaint about disability harassment, the school district should make sure that it ends immediately. The school might support the student who has been harmed by providing counseling and also counsel the individual or individuals responsible for the harassment. The district should follow up to make sure the harassment is resolved.

In the last thirty years, children with disabilities have become more integrated into our public school systems.

Students and teachers have learned to appreciate that everyone has differences. Sometimes, however, individuals are picked on because they are different or have special needs. Federal law requires that schools make sure that students are not picked on or harassed because they have a disability. Sticks and stones can break your bones, but words can break your heart. When those words harass a student based on the student's disability, they also break the law.

Randy Chapman is the Director of Legal Services at The Legal Center for People with Disabilities and Older People, Colorado's Protection and Advocacy System. He is the author of three books, including The Everyday Guide to Special Education Law, (The Legal Center 2005). For 29 years, he has been promoting and protecting the rights of people with disabilities. He can be reached at www.thelegalcenter.org or 1-800-288-1376.

Predictable Reactions Children Have to Their Parents' Divorce

By Marsha A. Temlock, MA

Divorce affects everyone in the family, especially children who will be mourning the loss of an absent parent, and dealing with all the changes in their environment. Children of all ages have a sea of emotions: sadness, depression, anxiety, confusion, fear, guilt and anger, and behave in ways you may not understand or agree with.

As a newly single parent or a parent who has begun to rebuild his or her life, you may begin to notice sudden changes in your child's behavior. For example, some children act out to get attention. (I used to be good, now I'll cause trouble.) Others withdraw and turn their anger inward. Bobby, who was so outgoing, goes off into a corner when there is company. The teacher reports that Janey refuses to share her toys in nursery school. You may observe your child crying at the least provocation, throwing tantrums, developing nervous habits such as nail biting or hair twisting, eating compulsively or rejecting food, wetting the bed, etc. These changes in personality can be both distressing and alarming.

In some cases, a grandparent, sibling or friend may be more aware of these changes in your child than you are. Understandably, you are focused on trying to reassemble your life, and it's very possible that you may not have personally observed these changes. Rather than wallow in guilt, begin by asking for specific examples for the changes in behavior and find comfort knowing that many changes are predictable, and, hopefully, temporary.

Obviously, if the changes are truly dramatic, it's time to seek professional help. But before you jump to conclusions that your child is in serious trouble, let me point out some common reactions children have to divorce.

First of all, bereavement counselors tell us that adults and children grieve differently. And yes, there is a certain amount of grieving that takes place during divorce

even if your child seems relieved that the fighting is over and the parents have parted ways.

Know that children cannot sustain long periods of grief. Also, their grief patterns are different from adults'. Their capacity is limited and because of this, their grief resurfaces at irregular intervals. There are bound to be flashbacks, such as a trip to the park where Daddy once cheered your son's winning baseball team, or a family gathering where Mommy's absence is all the more visible because the other cousins have both parents sitting at the table.

If it's tough for adults to make these connections or understand why they feel the way they do, imagine how difficult it must be for your child who is personally experiencing these flip-flops in mood and behavior.

Second, adults and children react differently to loss. Adults experience shock, disappointment, anger. Children, on the other hand, are more likely to experience feelings of abandonment.

Psychologists E.M. Hetherington and J. Kelley interviewed more than a hundred children of divorced families in their 1980 longitudinal study and learned that children who find out their parents are separating ask such questions as: Who will take care of me? Where will I live, go to school? Will the other parent leave, too?

Third, children have to blow off steam when expressing their feelings. Granted, it's not always easy to live with a child's turbulence that, hopefully, will dissipate in time. But keep in mind that blowing off steam is a way to test you while your child affirms you are an ally.

Fourth, recognize that there are developmental stages for children. Professionals in the field have compiled a list of predictable reactions that occur at specific ages that you can use as a guideline for evaluating behavior.

iors you notice in your child. Please note that this is a partial list, and since children move at different rates in their development, the ages in each category are approximate. [The list is based on information from Claudia M. Fetterman's Participant's Guide Putting Children First—Skills for Parents in Transition (1999) available from the Connecticut Council of Family Service Agencies.]

- From birth to 18 months, children may be nervous, fretful, and exhibit some delays in development. They need cuddle time, consistent routines and a feeling of security. Warning signs are failure to gain weight, diminished growth, or unresponsiveness.
- Toddlers (18 months to three years) may appear moody, withdrawn, fearful and become even more attention seeking. They may exhibit unusual changes in sleeping and eating patterns. Toddlers need verbal and physical assurance, routines and consistency. Obvious signs of regression are bed-wetting and tantrums.
- Preschool children (three to five years) do not understand the concept of divorce and may feel responsible for the situation. They may express fears unrelated to the divorce and will not want to separate from parents, fearing that one or both will not return. Again, they need reassurance the parent will return. You can read age-appropriate books to them about divorce and help them verbalize their feelings.
- Elementary school-age children (five to eleven years) will feel torn between parents, may take sides, and engage in magical thinking believing they can control the outcome and bring their parents back together if they behave a certain way. At this age, children will experience feelings of loss, anger, guilt, rejection and sadness. They may have difficulty sharing possessions and try to control situations. Adults should allow the children to expression their feelings, not offer false hopes, set structure and routines, avoid power struggles and encourage the child's relationship with the other parent.
- In middle and junior high school (eleven to fourteen years) children turn to peers for support. They worry how their own life will be affected, may become protective of a parent and play the role of the absentee parent. You may observe a child engage in negative acting-out behaviors, be critical of their parents' dating/social/sexual behavior. At this age, children need to express their feelings appropriately. You should encourage outlets such as exercise and sports. Children should have some input into visitation plans, and be given permission to act like a child.

- Older children of high school age will be concerned about money, resent the fact that their lives have been disrupted, may be afraid of intimacy, and be embarrassed by their parents' behavior. They are capable beyond age level and have the ability to understand and adapt with structure and guidance. Not all high school-age children, while articulate, are able to reason like adults. Parents need to continue to maintain parental control, give permission for children to love both parents, and develop an adult support system so the child can be free to be his/her age.

Does My Child Need Therapy?

This is a question most parents ask when they see their child acting out during their separation and divorce. As noted above, all children will go through a natural grieving period and have to process the changes in their life brought about by the family disruption. Some children need short-term problem-centered counseling. Teachers, school guidance counselors and social workers who observe your child will be able to advise you and recommend resources in the community. Many public schools have "Coping with your parents' divorce" workshops for children as young as kindergarteners.

Keep in mind that the decision to seek professional help is yours. Use the resources in your community that may include social service agencies, your child's guidance counselor, referrals from Human Resources or Employee Assistance departments at work, counseling centers in local colleges and community centers, pediatricians, churches or synagogues, professional societies of psychologists, clinical social workers and marriage and family therapists. Check your telephone directories, community hotlines such as Infoline, and the Web for listings in your area for professional counseling services. My book, *Your Child's Divorce: What to Expect – What to Do* (Impact Publishers, fall 2006) has an exhaustive listing of resources and will help you understand the importance of the extended family helping you and your children heal at critical stage of your divorce.

Ms Temlock is the author of Your Child's Divorce: What to Expect, What You Can Do. She writes a bi-weekly column for the New Canaan News-Review, is the travel, business and family life feature writer for Weston Magazine and writes for the Country Capitalist. She has worked for more than 20 years in social and psychological services.

Here's your second chance to win a \$50 Amazon gift certificate. Go to www.pedsforparents.com, click on "Contest" and then enter Contest 2. The password is "children."